LFUCG SATELLITE AGENCIES
2008

Employee Benefits Handbook

Employee Benefits Handbook

LFUCG

Table of Contents

Meet Your LFUCG Benefits Committee...

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- **Chris Bartley**
- **Rick Bowman**
- **Susan combs**
- **Hilton Hastings**
- **David Lucas**
- **Mary Lyle**
- **Brian Marcum**
- Kim Nesbitt
- Bill Van Pelt
- Alice Phillips
- Tracey Stephenson
- John Taylor
- Candace Wafford
- Chris Ward

The Committee's job was to review our existing benefits and make recommendations to the Mayor, Commissioners, and Council for changes, while keeping in mind the need for controlling costs. The Committee began meeting in January 2007 and has spent many hours reviewing the benefit package. The following pages are the result of those recommendations.

Employee Benefits Handbook

Benefits Overview

There are a lot of exciting changes this year, especially in the medical and dental plans. Because of the new plans, ***all employees must attend open enrollment to enroll in the plans of their choice, or decline coverage and show proof of other medical insurance coverage, i.e. medical card, letter from spouse's employer regarding coverage, etc.***

Medical Benefits
To aid LFUCG in controlling costs, beginning January 1, 2008, we will have one medical insurance carrier – Humana. However, within Humana, we will have two different medical plans: the Platinum Plan and Gold Plan. The Platinum and Gold Plans are both PPO's.

- The Platinum Plan has no deductible for in network services. Office visit charges are $15 for Primary Care Physician and $25 for Specialist.

- The Gold Plan has a $300/$900 deductible and office visit charges are $20/$35.

Pharmacy Benefits
Employees who enroll in the Humana Platinum Plan or Gold Plan will have pharmacy benefits through Pharmacare.

Dental Benefits
We have improved our Delta Dental Plans. The new Passive Plus Premier is a PPO plan that allows members to go to dentists either in or out of network. The annual maximum benefit has been increased to $2,500 per person, and it includes periodontal services. This plan also includes orthodontics for children and adults with a $1,000 lifetime maximum per person for this type of service. We also retained the regular Premier Plan, with 100% reimbursement across the board. The maximum benefit per person is $1,000.

Group Medical Benefits
LFUCG offers a self-funded medical plan which is administered by Humana. Two medical plans are offered this year – the Platinum Plan and the Gold Plan. Benefits for each of the plans are contained in this book. Employees can now elect to purchase Employee Only, Employee + Spouse, Employee + Child(ren), or Employee + Family coverage.

Pharmacy benefits are provided through Pharmacare for the Humana Platinum and Gold plans. Retail co-pays are still $10/$20/$40 and mail order co pays are $20/$40/$80.

Our medical plans are part of a qualified cafeteria plan and employee contributions are deducted prior to taxes being withheld.

Dental Benefits
This year LFUCG is offering two fully-insured dental plans through Delta Dental. The traditional Premier Plan has a $25/$75 deductible, then pays 100% of dental services up to $1,000 maximum per person per year. The PPO Plus Premier Plan also has a $25/$75 deductible, then pays 100% of diagnostic and preventive services, 80% of minor services such as fillings and extractions, and 50% of major services with in network providers. The maximum benefit per person per year has been increased to $2,500. Orthodontic services are paid at 50%, in network, for all covered members, with a $1,000 lifetime maximum.

HumanaPPO Summary of Benefits

LFUCG Platinum Plan

KENTUCKY	HumanaPPO 08 100/70 Plan	Plan pays for services at ***PARTICIPATING*** providers	Plan pays for services at ***NONPARTICIPATING*** providers
Preventive Care (1)	• Routine immunizations *(to age 18)* • Routine Pap smear • Annual routine mammogram • Routine lab test and X-ray • Preventive endoscopy *(includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)*	**100%**	**70%** after deductible
	• Routine adult physical exam *(18 years and above)* • Routine child exams *(to age 18)*	**100%** after office visit copayment	**70%** after deductible
Physician Services (1)	• Office visits • Diagnostic, lab and X-rays *(copayment does not apply)* • Allergy testing *(copayment does not apply)*	**100%** after $15 primary care physician/ $25 specialist copayment per visit	**70%** after deductible
	• Inpatient services • Outpatient services • Office surgery	**100%**	**70%** after deductible
	• Emergency room physician visits (2)	**100%**	**100%**
	• Allergy injections and nonroutine injections other than allergy	**100%** after $5 copayment per visit	**70%** after deductible
Facility Services	• Inpatient hospital care	**100%** after $500 copayment per admission	**70%** after deductible
	• Outpatient surgery • Outpatient nonsurgical care • Outpatient advanced imaging *(PET, MRI, MRA, CAT, SPECT)*	**100%**	**70%** after deductible
	• Hospital emergency services *(emergency room copayment waived if admitted)* (2)	**100%** after $75 copayment per visit	**100%** after $75 copayment per visit
Other Medical Services (3)	• Skilled nursing facility *(up to 100 day limits per calendar year)* • Home health *(up to 100 visits per calendar year)* • Physical, occupational, cognitive, speech and audiology therapy *(subject to combined limit for all therapy services up to 60 visits per calendar year)* • Durable medical equipment *(up to $5,000 per calendar year)*	**100%**	**70%** after deductible
	• Urgent care facility	Same as specialist copayment per visit	**70%** after deductible
	• Chiropractic services *(up to 25 visits per calendar year/plan year)*	**100%** after primary care physician copayment per visit	**70%** after deductible
	• Ambulance (2)	**100%** after deductible	**100%** after participating deductible
	• Transplant services	Same as any other covered condition when services are received from a Humana Transplant Network provider *(when services are received from a Humana Transplant Network provider)*	Same as any other covered condition *(covered expenses are limited to a maximum benefit of $35,000 per transplant)*
Deductible and Out-of-Pocket Maximum Accumulation Methods	• Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately		
Deductible *(per calendar year; copayments do not apply)*	• Individual	$0	$500
	• Family (4)	$0	$1,500
Out-of-Pocket Maximum *(per calendar year; deductibles and copayments do not apply)*	• Individual	N/A	$2,000
	• Family	N/A	Three times individual nonparticipating out-of-pocket maximum
Lifetime Maximum Benefit		$2,000,000 *(participating and nonparticipating combined)*	
Behavioral Health *(mental health and substance abuse)*	• Inpatient services • Outpatient therapy sessions	Same as any other covered condition	Same as any other covered condition

HumanaPPO Summary of Benefits

LFUCG Gold Plan

KENTUCKY	HumanaPPO 08 80/50 Plan	Plan pays for services at ***PARTICIPATING*** providers	Plan pays for services at ***NONPARTICIPATING*** providers
Preventive Care (1)	• Routine immunizations *(to age 18)* • Routine Pap smear • Annual routine mammogram • Routine lab test and X-ray • Preventive endoscopy *(includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)*	**100%**	**50%** after deductible
	• Routine adult physical exam *(18 years and above)* • Routine child exams *(to age 18)*	**100%** after office visit copayment	**50%** after deductible
Physician Services (1)	• Office visits • Diagnostic, lab and X-rays *(copayment does not apply)* • Allergy testing *(copayment does not apply)*	**100%** after $20 primary care physician/ $35 specialist copayment per visit	**50%** after deductible
	• Inpatient services • Outpatient services • Office surgery	**80%** after deductible	**50%** after deductible
	• Emergency room physician visits (2)	**100%**	**100%**
	• Allergy injections and nonroutine injections other than allergy	**100%** after $5 copayment per visit	**50%** after deductible
Facility Services	• Inpatient hospital care	**100%** after $500 copayment per admission	**50%** after deductible
	• Outpatient surgery • Outpatient nonsurgical care • Outpatient advanced imaging *(PET, MRI, MRA, CAT, SPECT)*	**80%** after deductible	**50%** after deductible
	• Hospital emergency services *(emergency room copayment waived if admitted)* (2)	**100%** after $75 copayment per visit	**100%** after $75 copayment per visit
Other Medical Services (3)	• Skilled nursing facility *(up to 100 day limits per calendar year)* • Home health *(up to 100 visits per calendar year)* • Physical, occupational, cognitive, speech and audiology therapy *(subject to combined limit for all therapy services up to 60 visits per calendar year)* • Durable medical equipment *(up to $5,000 per calendar year)*	**80%** after deductible	**50%** after deductible
	• Urgent care facility	Same as specialist copayment per visit	**50%** after deductible
	• Chiropractic services *(up to 25 visits per calendar year/plan year)*	**100%** after primary care physician copayment per visit	**50%** after deductible
	• Ambulance (2)	**80%** after deductible	**80%** after participating deductible
	• Transplant services	Same as any other covered condition when services are received from a Humana Transplant Network provider *(when services are received from a Humana Transplant Network provider)*	Same as any other covered condition *(covered expenses are limited to a maximum benefit of $35,000 per transplant)*
Deductible and Out-of-Pocket Maximum Accumulation Methods	• Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately		
Deductible *(per calendar year; copayments do not apply)*	• Individual	$300	Three times individual participating deductible
	• Family (4)	Three times individual participating deductible	Three times family participating deductible
Out-of-Pocket Maximum *(per calendar year; deductibles and copayments do not apply)*	• Individual	$2,000	Three times individual participating out-of-pocket maximum
	• Family	Three times individual participating out-of-pocket maximum	Three times family participating out-of-pocket maximum
Lifetime Maximum Benefit		$2,000,000 *(participating and nonparticipating combined)*	
Behavioral Health *(mental health and substance abuse)*	• Inpatient services • Outpatient therapy sessions	Same as any other covered condition	Same as any other covered condition

Prior authorization - Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at **Humana.com/members/tools/** or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Payments - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Participating primary care and specialist physicians and other providers in Humana's networks are <u>not</u> the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and specified as covered. Please see your Certificate for more information on medical necessity and other specific plan benefits.

(1) The following are generally defined as primary care physicians under your plan; general practitioner, family practitioner, pediatrician or internist.
(2) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.
(3) Visit and day limits are combined for participating and nonparticipating providers.
(4) You are not required to meet individual deductibles once the family deductible has been met.

The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

For general questions about the plan, contact your benefits administrator.

The Pre-existing condition exclusion information is applicable to all PPO and Classic products. If you are considering enrollment in an HMO or POS plan, please refer to your plan summary to determine if the plan contains a pre-existing condition exclusion.

PRE-EXISTING CONDITION EXCLUSION

If the plan imposes a pre-existing condition exclusion, and you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

HumanaPPO combines the cost-saving incentives of a modern health plan with freedom of choice. When you see participating providers, you receive the highest level of benefits available under your plan. At the same time, you retain the flexibility to see any physician.

HUMANA MEDICARE ADVANTAGE 2008 POLICE AND FIRE RETIREES, CEPF

In-Network	***Group Medicare Private Fee For Service***
Office Visit (Primary Care/Specialist)	$5/$15
In-Patient Hospital	$175 Co-Pay Admission
Out-Patient Surgery Facility	$50 Copayment
Other Out-Patient Services	$50 Copayment
Adult/Child Preventive Care	$0 copay , office visit copay will apply if other services are provided at the time of the visit
Emergency Room	$50 Copayment
Urgent Care Center	$15 Copayment
Pharmacy	$10/$20/$40/25%
Deductible	$0
Co-Insurance	None
Maximum Out-of-Pocket (excludes Deductible)	$2,500
Value Addes Services*	
SiverSneakers Fitness Program	*Humana Acitve Outlook Program*
TRUHearing Discount	*Quitnet -Smoking Cessation*
PrescibeIT - Over the Counter Discount	*Dental Discount*
EyeMed Vision Discount	*Humana 1st Nurses Line*
Monthly Premiums	
Employee	$159.00

*These products and services are neither offered nor guaranteed under Humana's contract with the Medicare program. These products and services are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process or the State Attorney General's office. Should a problem arise with any value-added item or service, please call Humana Customer Service for assistance.

ANTHEM SENIORS PLAN

The Anthem Seniors plan is a supplemental health insurance plan that is available to eligible individuals who are 65 or older and have Medicare parts A and B. Below are the outlined benefits:

Office visit	20% of the Medicare eligible expenses (DOES NOT PAY MEDICARE PART B DEDUCTIBLE)
Skilled Nursing	Plan pays 100% from days 1-20; Plan pays the Medicare Part A co-insurance (days 21-100); Plan pays 80% of Medicare Eligible Expenses up to an additional 365 days during your lifetime.
Private Duty	Pays 80% of maximum allowable amount. Annual maximum $2,500.00
Out of Hospital Prescription Drugs	80% of the Maximum allowable amount for outpatient prescription drug charges after a separate $100 deductible each calendar year, to a benefit period maximum benefit of $500 each calendar year.
Premium	$171.06 monthly with Rx coverage $138.35 monthly with no Rx coverage

Health Insurance Comparison

SATELLITE HEALTH INSURANCE COMPARISON JANUARY 1, 2008

	PPO					
	HUMANA PLATINUM PLAN			HUMANA GOLD PLAN		
Benefit	**In Network**	**Out of Network**		**In Network**	**Out of Network**	
Annual Deductible	$0	$500 Individual $1,500 Family		$300 Single $900 Family	$900 Single $2700 Family	
Office Visits	$15 Co-pay	Plan pays 70% After Deductible		$20.00 Co-pay	Plan pays 50% After Deductible	
Office Visits (Specialist)	$25 Co-pay	Plan pays 70% After Deductible		$35.00 Co-pay	Plan pays 50% After Deductible	
Primary Care Physician Required	No	No		No	No	
Routine Physicals	$15 Co-pay $25.00 Specialist	Plan pays 70% After Deductible		$20.00 Co-pay $35.00 Specialist	Plan pays 50% After Deductible	
Pre-Existing Conditions	N/A	N/A		N/A	N/A	
Well Child Care	$15 Co-pay	Plan pays 70% After Deductible		$20.00 Co-pay	Plan pays 50% After Deductible	
ER Visits (Life or Limb threatening only)	Plan pays 100% after $75 co-pay per visit	Plan pays 100% after $75 co-pay per visit		Plan pays 100% after $75 co-pay per visit	Plan pays 100% after $75 co-pay per visit	
Inpatient/Outpatient Hospital Charges	Plan pays 100% after $500 co-pay Per Admission Outpatient Surgery - Covered at 100%	Plan pays 70% After Deductible		Plan pays 100% after $500 co-pay Per Admission Outpatient Surgery - 80% after deductible	Plan pays 50% After Deductible	
Out-of-Pocket Maximum	* Single - N/A Family - N/A	* Single - $2,000 Family - $6,000		* Single - $2,000 Family - $6,000	* Single - $6,000 Family - $18,000	
TOTAL PREMIUM (Monthly)	**Single - $330** **EE + Spouse - $590** **EE + Child(ren) - $570** **EE + Family - $690**			**Single - $300** **EE + Spouse - $540** **EE + Child(ren) - $520** **EE + Family - $650**		
PHARMACARE PRESCRIPTION DRUG COVERAGE	$10 $20 $40	50% Co-pay		$10 $20 $40	50% Co-pay	

* Out-of-Pocket Maximum (per calendar year; deductibles and co-payments do not apply)

* * Out-of-Pocket Maximum (per calendar year; deductibles apply to out-of-pocket maximum)

- Prescription drug co-payments do not apply to the Platinum and Gold Plans' maximum out-of-pocket expense limit.

Non-Bargaining Total Pool Credit - $355.74 Monthly/$177.87 Per Pay Period

Vision Benefits

HumanaPPO Vision Plan 471 — $100 allowance plan/$10 copayment

Vision plan coverage

- This plan provides coverage for one vision exam and one pair of eyeglasses or contact lenses every 12 months for each covered member.
- For a complete list of participating optical providers, call 1-888-289-0595 or visit **www.humana.com**.

Services	Plan pays – participating providers	Plan pays – nonparticipating providers
Vision Examination		
• Exam with dilation as necessary	100% after $10 copayment	up to $35
Conventional and Disposable Contact Lenses Fit and Follow-up	100% after exam copayment	up to $40
Standard Plastic Lenses		
• Single vision	100% after $10 copayment	up to $25
• Bifocal	100% after $10 copayment	up to $40
• Trifocal	100% after $10 copayment	up to $55
Frames		
• Discount on all frames available except when prohibited by the manufacturer.	$100 allowance for any frame, plus member receives a 20% discount off balance over $100	up to $45
Contact Lenses (material only)		
• Conventional (excludes disposable)	$110 allowance, plus member receives a 15% discount off balance over $100	up to $100
• Disposable	$110 allowance	up to $100
• Medically necessary	$110 allowance	up to $100

Vision plan limitations and exclusions

No benefit is provided for:

1. Any vision service received more than once per 12 month period;
2. Contact lenses, if not in lieu of glasses;
3. Replacement of lost or damaged lenses, frames or contact lenses;
4. No-line bifocals;
5. Safety lenses and frames;
6. Nonprescription glasses or vision devices;
7. Two pair of eyeglasses in lieu of bifocals;
8. Medical or surgical treatment of the eyes;
9. Vision services provided as a result of any workers' compensation law or similar legislation, or obtained through or required by any government agency or program, whether federal, state, or any subdivision thereof;
10. Orthoptics, vision training or vision therapy;
11. Acute emergency eye care;
12. Discount on all frames available except when prohibited by the manufacturer.

Participating provider benefits apply only when services are obtained from an EyeMed *participating optical provider.*

Nonparticipating provider benefits apply only when services are obtained at a *nonparticipating optical facility.* To obtain reimbursement for services at a nonparticipating optical facility, you must submit a reimbursement form. You will be reimbursed according to Humana's benefit allowance schedule.

Vision Benefits

Vision plan limitations and exclusions *(continued)*

Reimbursement forms must include an itemized receipt containing your name, social security number, date of service, description of services received and the type of benefit received. To obtain a reimbursement form call 1-888-289-0595.

Member will receive a 20 percent discount on remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers. This additional discount does not apply to EyeMed providers' professional services. However, the discount program may be applied to services after the vision plan benefits have been provided. For example, you can use the vision plan to pay $100 towards frames, one time per year. In addition, you can receive a second pair of glasses by using the discount program's 45% off eyewear and discounts on lenses. Retail prices vary by location.

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Vision Discount Program

In addition to the plan benefits, Humana members also receive discounts for many vision services and materials. Use the discounts to help pay for services not covered by the vision plan. Some of these discounts and discounted fees are outlined on this page. For more information, visit Humana's Website at **www.humana.com. (Please note: Discounts are a feature of Humana membership, and not considered as insurance.)**

Discounts	Member pays – participating providers	Member pays – nonparticipating providers
Lens Options**		
• UV coating	$12	N/A
• Tint (solid or gradient)	$12	N/A
• Standard scratch-resistance	$15	N/A
• Standard polycarbonate	$35	N/A
• Standard progressive* (add-on to bifocal)	$45	N/A
• Standard anti-reflective	$45	N/A
• Other add-ons and services	20% discount	N/A
Laser Vision Correction		
• Lasik or PRK from US Laser Network	15% off retail price or 5% off promotional price	N/A

* The cost for Premium Progressive lenses equals the Standard Progressive lenses retail price plus a 20% discount on the balance over the price.

** Complete pair of glasses purchase: frame, lenses, and lense options must be purchased in the same transaction to receive the full discount.

Vision Discount Program limitations and exclusions

No discount is provided for:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, or supporting structures;
4. Corrective eyewear required by an employer as a condition of employment;
5. Services provided as a result of any Worker's Compensation law, or similar legislation, or required by any government age program whether Federal, state or subdivisions thereof;
6. Plan non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7. Services or materials provided by any group benefit providing for vision care;
8. Discount on all frames available except when prohibited by the manufacturer.

HUMANA.
Guidance when you need it most

GN-12635-HH 10/06

Pharmacy

Welcome to the PharmaCare Prescription Drug Program. PharmaCare is pleased to administer your prescription drug program, which enables you to:

- Conveniently obtain prescriptions through PharmaCare's national network of over 55,000 chain and independent retail pharmacies. Immediate care prescriptions may be filled at retail pharmacies and will be handled through the PharmaCare Pharmacy Network. You must present your PharmaCare Prescription Drug Card to the pharmacist when filling prescriptions at a retail pharmacy. A partial listing of participating pharmacies for the retail program is included on page 7.

- Conveniently obtain maintenance prescriptions through PharmaCare's mail-service pharmacy, PharmaCare Direct.

Please read the following information carefully. If you have any questions about the program, feel free to contact PharmaCare Customer Service at 1-888-645-9303 or visit PharmaCare's Web site at **www.pharmacare.com/members**.

The PharmaCare pharmacy benefit program is available to you and your eligible family members. The following is a summary of the pharmacy benefits you will receive; you have two benefit options available under your prescription drug program:

1. With the retail pharmacy program you may receive up to a 30-day supply of medication from a PharmaCare network retail pharmacy for short-term medications such as antibiotics.

2. If you or a covered family member regularly takes medication for chronic, long-term conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc., you may receive up to a 90-day supply of maintenance medication through PharmaCare's mail-service pharmacy, PharmaCare Direct. The prescription will be delivered directly to your home. To enroll in the mail-service program, fill out the Confidential Mail Service Enrollment Form (found on page 9) and mail it with your first prescription and co-payment to PharmaCare Direct.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
Co-payment, coinsurance or copay means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

PHARMACARE

COVERED SERVICES

Covered medications must meet the following requirements:

- Prescribed by a licensed doctor;
- The prescription medication is approved by the Food and Drug Administration (FDA); and,
- Purchased at a PharmaCare participating retail network pharmacy or through PharmaCare Direct.

Certain medications may not be covered under the prescription drug plan. Please refer to your benefit plan documents for more information.

PAYMENTS YOU MUST MAKE

- Plan co-payments:

	Maximum Day Supply	Generic	Formulary Brand	Non-Formulary Brand
Retail	30 days	$10	$20	$40
Mail Service (PharmaCare Direct)	90 days	$20	$40	$80
PharmaCare Specialty Pharmacy	30 days	$10	$20	$40

Only the Platinum and Gold Plans will use the Pharmacare Prescription Plan

Delta Dental Premier

Traditional Dental Option

DELTA DENTAL®

Dental Benefits for Lexington Fayette Urban County Government

This is not a contract. It is a *partial list* of benefits and services. *For complete details refer to your certificate.*

Deductible
(Each Benefit Period) $25 individual/$75 family

Maximum Benefits
(Per Covered Person each Benefit Period) $1,000

Age Limitations Dependents covered up to age 23, full-time students up to age 23.

Diagnostic and Preventive Services

Reimbursement Amount
100% of the Allowable Amount
Deductible does not apply

- Oral examination (limited to 2 per calendar year)
- Palliative emergency treatment
- Periapical, bitewing, panoramic or complete series x-ray
- Topical fluoride application (up to age 19)
- Routine cleanings
- Sealants (up to age 16)
- Space maintainers (up to age 11)

Minor Services

Reimbursement Amount
100% of the Allowable Amount
Subject to deductible.

- Routine fillings
- Simple extractions
- Root canal therapy
- Simple denture repair
- Oral surgery

Major Services

Reimbursement Amount
100% of the Allowable Amount
Subject to deductible.

- Inlays or crowns
- Prosthetic services (bridges, dentures and partials)

Please note: Dentists who have signed participating agreements with Delta Dental of Kentucky agree to accept the Allowable Amount as payment in full for Covered Services as these terms are defined in the Certificate of Coverage. Each Covered Person is responsible for the amount of Coinsurance, Deductible, and non-covered charges. Dentists who have not signed a participating agreement may bill you directly for any amount of their charge in excess of the Allowable Amount. In cases where the dentist's charges exceed the Allowable Amount, your coinsurance will be larger. Certain procedures require preauthorization and/or are subject to limitations.

Delta Dental PPO Plus Premier

Dual Network Option

DELTA DENTAL®

Dental Benefits for Lexington Fayette Urban County Government

This is not a contract. It is a *partial list* of benefits and services. *For complete details refer to your certificate.*

This dental program allows members to utilize any licensed provider. Members who choose a Delta Dental PPO network provider have the lowest out of pocket expenses and cannot be balance billed. Members who choose a Delta Dental Premier network provider cannot be balance billed.

	Delta Dental PPO Network Benefits	Delta Dental Premier or Out of Network Benefits
Deductible (Each Benefit Period)	$25 individual/$75 family	$25 individual/$75 family
Maximum Benefits (Per Covered Person each Benefit Period)	$2,500	$2,500
Age Limitations	Dependents covered up to age 23, full-time students up to age 23.	
Diagnostic and Preventive Services ♦ Oral examination (limited to 2 per calendar year) ♦ Palliative emergency treatment ♦ Periapical, bitewing, panoramic or complete series x-ray ♦ Topical fluoride application (up to age 19) ♦ Routine cleanings ♦ Sealants (up to age 16) ♦ Space maintainers (up to age 11)	**Reimbursement Amount** 100% of the Allowable Amount Deductible does not apply	**Reimbursement Amount** 80% of the Allowable Amount Deductible does not apply
Minor Services (Class I, II and III) ♦ Routine fillings ♦ Simple extractions ♦ Simple denture repair ♦ Oral surgery ♦ Periodontic services	**Reimbursement Amount** 80% of the Allowable Amount Subject to deductible.	**Reimbursement Amount** 60% of the Allowable Amount Subject to deductible.
♦ Root canal therapy	50% of the Allowable Amount Subject to deductible	50% of the Allowable Amount Subject to deductible
Major Services (Class IV) ♦ Inlays or crowns ♦ Prosthetic services (bridges, dentures and partials)	**Reimbursement Amount** 50% of the Allowable Amount Subject to deductible.	**Reimbursement Amount** 50% of the Allowable Amount Subject to deductible.
Orthodontic Services ♦ Diagnosis and treatment plan ♦ Minor treatment for tooth guidance	**Reimbursement Amount** 50% of the Allowable Amount Deductible does not apply Benefits are limited to $1,000 lifetime maximum for covered persons.	**Reimbursement Amount** 50% of the Allowable Amount Deductible does not apply

Please note: Dentists who have signed participating agreements with Delta Dental of Kentucky agree to accept the Allowable Amount as payment in full for Covered Services as these terms are defined in the Certificate of Coverage. Each Covered Person is responsible for the amount of Coinsurance, Deductible, and non-covered charges. Dentists who have not signed a participating agreement may bill you directly for any amount of their charge in excess of the Allowable Amount. In cases where the dentist's charges exceed the Allowable Amount, your coinsurance will be larger. Certain procedures require preauthorization and/or are subject to limitations.

Dental benefits are offered by Delta Dental of Kentucky, Inc.

2006-0046

Delta Dental Plan Highlights at a Glance

The following gives you a summary description of each plan benefit. If you have any questions after reviewing all the materials, please call Delta Dental at (800) 955-2030.

Lexington Fayette Urban County Government

	Delta Dental Premier	*Delta Dental PPO Plus Premier*	
		Delta Dental PPO In-Network	***Delta Dental Premier or Out-of-Network***
Deductible (Calendar Year)	$25 Individual $75 Family	$25 Individual $75 Family	$25 Individual $75 Family
Preventive Services	(Deductible does not Apply)	(Deductible does not Apply)	(Deductible does not Apply)
Oral Exams	100%	100%	80%
X-Rays	100%	100%	80%
Teeth Cleaning	100%	100%	80%
Fluoride Treatments	100%	100%	80%
Minor Services	(Subject to Deductible)	(Subject to Deductible)	(Subject to Deductible)
Fillings	100%	80%	60%
Extractions	100%	80%	60%
Oral Surgery	100%	80%	60%
Root Canals	(Subject to Deductible) 100%	(Subject to Deductible) 50%	Subject to Deductible 50%
Periodontics	Not covered	(Subject to Deductible) 80%	(Subject to Deductible) 60%
Major Services	(Subject to Deductible)	(Subject to Deductible)	(Subject to Deductible)
Crowns	100%	50%	50%
Bridges	100%	50%	50%
Dentures	100%	50%	50%
Dependents	Dependents covered up to age 23	Dependents covered up to age 23	Dependents covered up to age 23
Orthodontics (Braces)	Not covered	(Not subject to Deductible) 50% limited to $1,000 lifetime maximum for covered members	(Not subject to Deductible) 50% limited to $1,000 lifetime maximum for covered members
Annual Maximum	$1,000	$2,500	
Network	Any Dentist participating in Delta Dental Premier. You may be balanced billed if you see non-participating dentists.	Any Dentist participating in Delta Dental PPO	Your benefits will be reduced and you may be balance billed* if you see a non-participating Delta Dental PPO dentist

1/2008

Core Benefit Cost Comparison

SATELLITE Core Benefit Premium Cost Comparison - 01/01/2008 - 12/31/2008

HEALTH INSURANCE

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	COBRA Single	COBRA EE + Spouse	COBRA EE + Child(ren)	COBRA EE + Family
Humana Platinum	**$330.00**	**$590.00**	**$570.00**	**$690.00**	**$336.60**	**$668.10**	**$581.40**	**$962.88**
Per Pay Period	$ 165.00	$ 295.00	$ 285.00	$ 345.00				
Humana Gold	**$300.00**	**$540.00**	**$520.00**	**$650.00**	**$306.00**	**$617.10**	**$530.40**	**$922.08**
Per Pay Period	$ 150.00	$ 270.00	$ 260.00	$ 325.00				

Humana Vision Care & Pharmacy coverage are included with the Health Insurance Premium

DENTAL INSURANCE

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	COBRA Single	COBRA EE + Spouse	COBRA EE + Child(ren)	COBRA EE + Family
Delta Premier	**$28.00**	**$56.00**	**$53.00**	**$86.00**	**$28.56**	**$57.12**	**$54.06**	**$87.72**
Per Pay Period	$ 14.00	$ 28.00	$ 26.50	$ 43.00				
Delta Passive PPO	**$20.00**	**$40.00**	**$50.00**	**$76.00**	**$20.40**	**$40.80**	**$51.00**	**$77.52**
Per Pay Period	$ 10.00	$ 20.00	$ 25.00	$ 38.00				

Prudential Life Insurance

	Basic - $10,000	Basic - $7,500
	$ 1.80	**$ 1.35**
Per Pay Period	$ 0.90	$ 0.68

1, 1.5, 2, 2.5, or 3 X Annual Salary based on age and rates

<25	$0.125	50-54	$0.505
25-29	$0.145	55-59	$0.93
30-34	$0.17	60-64	$1.15
35-39	$0.18	65-69	$1.96
40-44	$0.225	70+	$3.90
45-49	$0.30		

Plan I	Plan II	Plan III
4.88	3.54	1.68
2.44	1.77	0.84

NON-BARGAINING TOTAL POOL CREDIT - $355.74 M0NTHLY / $177.87 PER PAY PERIOD

OPEN ENROLLMENT 2008 SCHEDULE

It is not mandatory that employees attend at the locations and times shown below, but it will go a long way toward preventing the problem of long lines, since all employees are required to attend Open Enrollment in order to have coverage. Satellites are welcome to attend any of the sessions.

Monday, December 3, 9:00 a.m. - 4:00 p.m.—Government Center Ballroom

- Computer Services
- Council Clerk's Office
- Council Office
- Internal Audit
- Mayor's Office

Tuesday, December 4, 9:00 a.m. - 4:00 p.m.—Division of Community Corrections

- Community Corrections
- General Services
- Public Works

Wednesday, December 5, 11:00 a.m. - 7:00 p.m.—Division of Police West Sector Gym

- Police
- Streets and Roads
- Social Services

Thursday, December 6, 9:00 a.m. - 4:00 p.m.—Division of Waste Management

- Air and Water Quality
- Public Works
- Waste Management

Friday, December 7, 9:00 a.m. - 4:00 p.m.—Fire Training Center

- Budgeting
- Finance and Administration
- Fire
- Law

Note: Satellite agency employees, other than Police & Fire retirees, may attend any Open Enrollment session to obtain material. Enrollment will occur with your individual agencies.

MAKING CHANGES

If your agency has a cafeteria plan, the medical and dental plans are administered in accordance with IRS Section 125 tax code, which allows for a tax advantage (premiums may be deducted on a "pre-tax" basis) for all employees who wish to participate. Because of this tax advantage the tax code limits the changes that an employee can make to their plan elections or enrollment into a plan at any time other than open enrollment. If your agency does not have a cafeteria plan, then check with your agency to see what their rules are for adding and dropping dependents.

- Employees may not change his/her plan elections during the year unless a change in family status occurs. A list of exceptions follows:
- Cancellation of dependent coverage due to dependent ineligibility (divorce or child reaching age 23)
- Acquiring a new dependent through marriage, birth or adoption.
- Obtaining other coverage through a spouse's employer, providing that a qualified status change has occurred.
- Change in employment status from part-time or temporary to full-time.
- Change in employment status from full-time to part-time or temporary or termination of employment.
- Loss of coverage under spouse's employer plan due to a spouse's death, termination of employment, divorce, or loss of eligibility for other coverage.
- Qualified medical child support court order.

Important Notice

All election changes made (other than during the annual enrollment period) due to a qualified status change must be made within 31 days of the event date and must be consistent with the status changes identified on this page. An employee will be required to provide proof of the qualified status change, proof of other coverage in force, and/or proof that other coverage has been lost.

Contact Information

Humana

- Humana customer service 1-800-448-6262 Group # 211791
- My Humana Employee Service – www.humana.com
- Mail claims to: P.O. Box 14601 14601 Lexington, KY 40512-4601
- Mental Health – 1-866-260-5266
- Humana First nurse assistance – 1-800-622-9529

Pharmacy

- Pharmacare customer service 1-800-645-9303 Group #200133343
- Pharmacare Direct mail service – www.pharmacare.com/members

Delta Dental of Kentucky

- Employee customer service – 1-800-955-2030 Group # M00034
- Employee self service - www.deltadentalky.com (order cards, look at benefit information)
- Mail claims to: P.O. Box 242810 Louisville, KY 40224-2810